Family Care - Managed Care Organizations –

This section is applicable to managed care organizations contracted with the Department of Health Services to operate Family Care, Family Care Partnership, and PACE.

Funding: Medical Assistance, CFDA number 93.778); however, the department does not consider this program to be federal financial assistance and OMB Circular A-133 is not applicable.

Background - Family Care, Family Care Partnership and PACE managed long-term care programs improve coordination of long-term care (LTC) services by creating a single flexible benefit for services. Managed Care Organizations (MCOs) operating Family Care contracted to cover specific LTC services are funded by Medicaid. MCOs operating Family Care Partnership and PACE contracted to cover specific acute and primary and LTC services are funded by Medicaid and Medicare. A list of the required services offered by contracted MCOs is available in the description of the long-term care benefit package in the Family Care, Family Care Partnership and PACE Contracts.
(http://dhs.wisconsin.gov/LTCare/ProgramOps)

Managed Care Organizations (MCOs) receive an actuarial sound per member per month (PMPM) capitation payment for each enrollee to manage the care for all MCO recipients who are living in their own homes, community based residential settings, or nursing facilities. MCOs will:

- Develop and manage a comprehensive network of services and supports, and deliver some services directly through MCO staff.

- Conduct a comprehensive assessment of individual's needs, abilities, preferences and values with the consumer and family/guardian. The Care Management Team, consisting of at least a social service coordinator and registered nurse, the member, and informal supports jointly participates in completing a comprehensive assessment that looks at areas such as activities of daily living, physical health, nutrition, autonomy and self-determination, communication, and mental health and cognition.

- Design a care plan in partnership with the consumer, based on information gathered during the comprehensive assessment and tailored to the individual's needs, preferences and outcomes.

- Be responsible for the quality of care and services consumers receive, and for continually improving the quality of care and services.

Unless indicated otherwise, all compliance requirements in this section reflect the Family Care, Family Care Partnership and PACE contracts between the department and MCOs. The auditor should refer to the actual contract and any supplementary materials when assessing how a requirement applies to a particular MCO.

Auditor qualifications - Family Care is a risk-based managed care program. The independent CPA audit team should include members with insurance or managed care audit experience.

Sending the audit report to the department – The auditor should refer to the MCO Family Care, Family Care Partnership, or PACE contract with DHS for the audit report submission requirements.

Risk assessment

The Department of Health Services considers the Family Care Program to be a high risk program for the purposes of planning the annual independent audit by an external CPA audit firm for the decisions around testing, sample size, materiality, and individually significant items.

Compliance requirements and suggested audit procedures

1 General accounting requirements

Compliance Requirement: The Family Care, Family Care Partnership and PACE contracts require the Managed Care Organization to maintain a full accrual accounting system in accordance with Generally Accepted Accounting Principles (GAAP). Audited financial statements must be presented on a GAAP basis. Family Care Partnership and PACE programs must also meet the HMO reporting requirements of a statutory presentation for submission to the Office of the Commissioner of Insurance (OCI).

Suggested audit procedures:
Standard audit procedures and sampling of accounting transactions should be completed to determine compliance with Generally Accepted Accounting Principles including

- Review of accounting policies and procedures to assure consistency with generally accepted accounting principles (GAAP).

- Interview the Chief Financial Officer or responsible financial person to assure they have a working understanding of generally accepted accounting principles as they relate to a risk- based, capitated managed care contract.

Compliance Requirement: The Family Care, Family Care Partnership and PACE contracts require the Managed Care Organization to maintain an internal control environment sufficient to ensure the reliability of the financial reporting compliance with laws and regulations, and safeguarding of the assets.

Suggested audit procedures: Review the policies and procedures and conduct relevant staff interviews in order to evaluate and document the auditor's understanding of the internal control environment. Include a report on the internal control environment in the final audit report as described in the DHS contract.

2 Capitation receivable

Compliance Requirements: The reliability of the financial statements is largely dependent on the accuracy of the Managed Care Organization's accounting methodologies and estimates for its Capitation Revenue. Furthermore, management of this revenue source is complex and is critical to the solvency of the MCO. The MCO must develop adequate processes, procedures and systems to accurately track the collection of capitation for each eligible and enrolled member in a timely fashion. Furthermore, the MCO must understand basic program eligibility requirements to coordinate enrollment efforts, recognize capitation revenue as it is receivable, record unearned revenue resulting from enrollment/disenrollment date differences, write-off capitation revenue as necessary, and follow up on open, but unresolved, enrollment and resulting capitation issues. The MCO must have a process to accurately reconcile and follow up on monthly enrollment and capitation reports generated by the Medicaid program Forward Health interChange system, against the active membership identified and maintained in the MCO data system.

Suggested audit procedures:

- Review and evaluate the Managed Care Organization's process for ongoing reconciliation of its records to the state reports and data systems to ensure that:
    1) Enrolled members are served and
    2) members no longer enrolled do not continue to receive service unless a specific decision to continue serving was made and documented with a transition plan to ensure continuity of care.
- Review the detailed capitation receivable report by member and month generated from the database the MCO is using to reconcile membership/capitation. Sample the report records to determine if:
    1) The policies related to eligibility are consistently applied.
    2) The MCO has taken the appropriate action/coordination in accordance with State and MCO policies, to resolve date of enrollment discrepancies, which may result in delayed capitation payment, capitation at an incorrect level of care (LOC), capitation with an incorrect cost share deduction, or a capitation payment that the MCO is not entitled to and recorded as unearned revenue.
    3) The capitation amount claimed as receivable corresponds to the contracted rate at the appropriate LOC as identified in the state capitation reports.
    4) If the capitation receivable is netted against unearned capitation, verify the reasonableness of the payable portion of the receivable. If the capitation receivable is not netted against unearned revenue/capitation, verify that it is reported as a payable and is tracked and followed up on so a recoupment by the state is initiated as appropriate.

- Trace a sample of members claimed as receivable from the prior year report to the remittance payment report to verify receipt.

- Determine the reasonableness of the prior year capitation receivable and payable by comparing the prior year estimated receivable and payable to a report of capitation received and deposited and capitation reports demonstrating recoupments for the prior year capitation payable in the audit year for prior year dates of service.

- Trace a sample of members claimed as receivable and payable for the current audit year to subsequent payment remittance reports to verify receipt and/or recoupment.

- Evaluate follow-up on open issues and reasonableness of ongoing status as a receivable or payable.

3 Member receivable

Compliance Requirement: The MCO is responsible for monitoring, invoicing, and collecting the member's monthly cost-share as determined by county Income Maintenance (IM) staff, the member's monthly room and board and spend down.

Suggested Audit Procedures:

- Review and evaluate the policy and procedures used for invoicing, collecting and reconciling cost share, room and board and spend down.

- Compare member cost-share and spend down requirements from the monthly Cost Share Report and the capitation report against amounts invoiced and collected on the accounts receivable ledger to assure the accuracy of the collections and stated receivable. Review documentation to explain variances and related follow-up that may be due to timing, error, etc.

- Compare the Room and Board receivable against source documentation to calculate member specific room and board with amounts invoice and collected to assure the accuracy of the stated receivable. Review documentation to explain variances and related follow-up that may be due to timing, error, etc.

- Review the aging and balances of outstanding accounts to evaluate the probability of actual collections as it relates to the receivable estimate and allowance for uncollectible accounts.

- Review non-payment of cost share greater than 60 days and compliance with policy and procedure for non-payment of cost share. (Non-payment of cost share affects a member's financial eligibility for participation in the Family Care Program, see MCO contract for more information).

- Review the credit balances and process for issuing refunds. Sample and test against the policy and procedure.

- Review member receipts posted after year-end to determine the accuracy of the member receivable estimate.

4 Client funds

Compliance Requirement: A MCO might act as a fiduciary for client funds. Wis. Statutes and the Social Security Administration provide guidance on the responsibilities of fiduciaries.

Suggested Audit Procedures: If the MCO has fiduciary responsibility for client funds, review the MCO procedures for management of those funds to determine whether the MCO:

- Maintained adequate internal controls over client funds, such as segregation of duties for authorizing disbursement of client funds and disbursing those funds.

- Maintained appropriate documentation for disbursement of client funds.

- Had written authorization from the client or the client's guardian, agent, or designated representative to hold the resident's funds.

- Segregated client funds from the MCO's funds.

- Maintained written records of the client's funds and provided reports of the funds to clients, guardians, agents, or designated representatives reporting receipt and disbursement details.

For MCOs that are operated by a county, the provisions in this section may be tested as part of the general compliance testing for client funds during the County audit.

5 Incurred but not reported provider claims (IBNR)

Compliance Requirements: The reliability of the financial statements is largely dependent on the accuracy of the Managed Care Organization's accounting methodologies and estimates for its incurred but not reported (IBNR) provider/vendor claims. Each MCO has been instructed to develop and monitor its own methodology based on their expertise of their unique claims payment systems. More than one method should be developed to assist in estimating IBNR as accurately as possible. The managed care industry, in general, has learned that although a single methodology may be accurate in any given year, anomalies can and do occur and can cause an estimate to be materially under or over estimated.

Furthermore, the monitoring of the methodology is necessary to facilitate refining methodologies as systems and procedures change and to facilitate disclosure of material variances from estimated IBNR (in particular prior year).

Suggested audit procedures:

- Some MCOs include claims entered into the claims system not yet paid as part of IBNR. Verify this payable to the source document and check the IBNR calculation to assure that these payables have not been "double counted" as accounts payable and in the IBNR estimate.

- Review prior year IBNR methodology and estimate by comparing the prior year IBNR by month to claims paid (by date of service) by month. This is referred to as a lag or triangle report. For example:

  Prior Year IBNR (2008 accounting) as stated on the prior year Financials equals $5,000,000. Compare the $5 million estimate to the claims that actually paid out for the prior year dates of service (2008), paid in the audit year (2009). The lag will be similar to the following illustration:

		Date of Service		
Paid Date	**Jan-Sep-08**	**Oct-08**	**Nov-08**	**Dec-08**
Jan-09	$100,000	$200,000	$500,000	$1,000,000
Feb-09	$ 75,000	$150,000	$300,000	$ 650,000
Mar-09	$ 50,000	$ 75,000	$125,000	$ 500,000
Etc.	$ 25,000	$ 45,000	$ 85,000	$ 130,000
Total	$250,000	$470,000	$1,010,000	$2,280,000

Total paid	$4,010,000
PY IBNR	$5,000,000
Total overestimated	$990,000

Unless previously adjusted by the MCO, the overestimated IBNR amount is therefore included as part of the current year incurred. It is important for the MCO to note this, since a material over/under estimate will misrepresent the member services expenses reported on the Revenue and Expense Statement. For example:

Member Services as noted on the Revenue and Expense Statement	$60,000,000

Without any additional reference, one would erroneously assume that the current year member expenses were approximately $60 million. Once the over/under estimate is disclosed, one could correctly note that current year member expenses are approximately $59,010,000 with a $990,000 benefit of having "over reserved" the IBNR.

Example audit work paper:

	IBNR as Estimated	Actual per lag	Variance
Dec	$2,500,000	$2,280,000	$220,000
Nov	$1,500,000	$1,010,000	$490,000
Oct	$ 500,000	$ 470,000	$ 30,000
Sep	$ 250,000	$ 250,000	$ 0
Etc.	$ 250,000	$ 0	$250,000
Total	$5,000,000	$4,010,000	$990,000

The Auditor should verify the over/under prior year estimate and ensure it is disclosed on the MCO financial statement in the notes to the financial statements or as a separate line item on the revenue and expense statement.

- Review current year IBNR estimate by reviewing the lag of paid claims (see example above) for current (audit) year dates of service paid after the current year-end (the lag can be run for paid claims through most recent payment date, probably March or April). The audit work paper will look something like the following illustration:

	IBNR	Paid Jan	Paid Feb	Paid Mar	Remaining IBNR
Dec	$3,500,000	$2,250,000	$ 750,000	$ 750,000	($250,000)
Nov	$2,750,000	$1,500,000	$ 500,000	$ 250,000	$500,000
Oct	$ 750,000	$ 500,000	$ 150,000	$ 100,000	$ 0
Sep	$ 250,000	$ 250,000	$ 50,000	$ 25,000	($ 75,000)
Etc.	$ 250,000	$ 75,000	$ 50,000	$ 25,000	$100,000
Total	$7,500,000	$4,575,000	$1,500,000	$1,150,000	$275,000

In this case, there are under reserved months and months that have adequate IBNR to cover future claims. The auditor needs to work with the MCO to revise or agree with the estimate. The auditor should encourage the MCO to re-estimate the IBNR if the analysis shows a material variance to the initial estimate.

A sample work paper will look something like the following illustration:

	Remaining IBNR	Estimated IBNR	Revised IBNR
Dec	$3,500,000	($250,000)	$4,000,000
Nov	$2,750,000	$500,000	$2,500,000
Oct	$ 750,000	$ 0	$ 850,000
Sep	$ 250,000	($ 75,000)	$ 375,000
Etc.	$ 250,000	$100,000	$ 200,000
Total	$7,500,000	$275,000	$7,825,000

- Auditor analysis should "re-estimate" and support the work paper month by month, since months of "over estimate" do not necessarily offset the months of "under estimate" or vice versa.

- Review the current and prior year IBNR to assess the reasonableness of the method utilized by the MCO to estimate and subsequently adjust its IBNR. The Department has recommended that the

MCOs use additional detailed methodologies such as percent of completion by service categories by month, PMPMs by service category by month, and/or service authorization to paid claims by service category by month.

6 Capacity for financial solvency and stability

The contract between the Permitted Family Care MCO, not operated by a licensed HMO, and the Department includes provisions for demonstrating that the MCO has the capacity to assume the financial risks associated with that contract. The MCO's financial capacity consists of three components: working capital, restricted reserve, and solvency protection.

Working Capital

Compliance requirements:

The purpose of the working capital is to provide ongoing liquid assets to manage routine fluctuations in revenue and expenses that will occur in the day-to-day normal course of business operations.

Working capital is the difference between current assets and current liabilities. An MCO's working capital shall not be less than 2.5% of the budgeted annual capitation payments from the department to the MCO for the period of the 2010 contract.

Suggested audit procedures:

- Verify the cash balance to the bank statement. If the MCO is part of a County and does not have a separately identifiable bank account, verify the MCO's cash detail to the County to assure the cash balance has been agreed upon by the County (verify to the County's general ledger balance).

- Verify the classification of assets and liabilities as "current" by reviewing source documents for prepaid expenses, other assets not reviewed elsewhere and other liabilities not reviewed elsewhere.

- Substantiate the current assets and liabilities by reviewing appropriate source documentation. Make a determination that the Balance Sheet assets and liabilities are appropriately classified according to GAAP.

- Compare the calculated working capital to the Family Care contractual requirements as detailed in the annual certification memo from DHS that provides the annual requirements based on the MCO's projected and approved budget.

Restricted Reserve

Compliance requirements:

The purpose of the restricted reserve is to provide continuity of care for enrolled members, accountability to taxpayers, and effective program administration including the ability to manage the operation of the MCO as a separate and distinct fund with adequate liquid assets to manage volatility of the program.

The MCO shall establish and maintain a separately identifiable investment reserve account on the chart of accounts to meet the restricted reserve requirements of the contract. Deposits to and withdrawals from the restricted reserve are to be clearly identifiable within the account and the accounting system and supported by documentation. Documentation of approval of disbursements in compliance with the Family Care contract Section XVII, Section A.2.b.iv should be provided by the MCO.

The required minimum balance is calculated for the contract year based on the annual budgeted capitation projected by the MCO and communicated by DHS in a certification memo formalizing the annual requirement. The 2010 calculation is as follows:

- 8% of the first $5 million of annual budgeted capitation
- 4% of the next $5 million of annual budgeted capitation
- 3% of the next $10 million of annual budgeted capitation
- 2% of the next $30 million of annual budgeted capitation
- 1% of any additional annual budgeted capitation.

Any income or gains generated by the restricted reserve funds are to remain within the account until the balance reaches the required minimum balance. The MCO may only make disbursements from the restricted reserve account as set forth in the MCO contract Section XVII, Section A.2.b.iv. The MCO must provide an investment report for the restricted reserve account as part of the required financial reporting submitted to the Department.

Suggested audit procedures:

- Verify the balance of the restricted reserve account reported on the year-end MCO balance sheet to the supporting investment statement.

- Compare the required risk reserve amount as provided in the annual memo from DHS, which calculates the requirements for the MCO based on the MCO's approved budget, to the actual risk reserve amount and note the adequacy or deficiency.

- Verify that earnings generated by the restricted reserves remain in the restricted reserve account as demonstrated on the balance sheet.

- Determine whether the MCO obtained prior approval from the department for any disbursements from the restricted reserve account that resulted in an account balance below the required minimum balance.

Solvency Reserve

Compliance requirements:

The solvency fund provides for continuity of services and smooth transition of members from the existing MCO to another entity as described in Article XVI.E. of the MCO contract or in the event the existing MCO becomes irreversibly insolvent. The MCO must deposit an amount of $750,000 into an account designated by the Department and held by the Department of Administration.

- The solvency fund balance must be reported on the MCO's balance sheet.
- Income generated by the funds will be recognized by the MCO and remain within the account until the MCO meets the required minimum balance as set forth in the MCO contract.
- Income or gains generated by the solvency fund beyond the minimum balance may be used as set forth in the MCO contract Section XVII, Section A.2.c.v.

Suggested audit procedures:

- If the solvency fund requirements are not fully funded review documentation of funding plans as approved by the OCI.
- Compare the amount recorded on the balance sheet to the investment statement.
- Trace any investment earnings reported on the income statement to the investment statement.

7 Capitation revenue

Compliance Requirement: In full consideration of services in the benefit package rendered by the MCO for each enrolled member, DHS pays the MCO actuarially determined monthly capitation payments based on the per member per month (PMPM) payment rate specified in the MCO Specific Contract Terms, Capitation Rate section of the Family Care, Family Care Partnership and PACE contracts. Capitation Revenue should be recognized and reflected on the Revenue and Expense Statement on an accrual basis according to GAAP.

Suggested audit procedures:

- Verify total capitation accounted for as received to the State capitation reports paid (regardless of date of service) *see section 2, capitation receivable section*.

- Verify total capitation payments are accounted for in the MCO's general ledger system and/or to the MCO's total capitation receipts system/database. Note that each MCO has different systems/databases in place to track capitation received for each member and each should be able to generate a report of capitation received by member, which should then tie to the general ledger as the supporting detail.

- Verify the calculation of accrued capitation revenue to the capitation revenue reported on the Revenue and Expense Statement. The verification work paper for accrued capitation revenue should reflect this calculation.

8 Care management services

Compliance Requirements: Care management service expense can be based on a calculated internal allocation process and/or as a service purchased from a contracted vendor(s). Care management services are material program expenditures that DHS actuaries include in the service component of the rate setting process.

Suggested audit procedures:

- Review allocations, methodologies and supporting documentation including wages, benefits, direct and indirect/allocated expenses of the care management staff of internal care management rates to determine the reasonableness against the rate approved by the Department for the audit year. The MCOs are required to submit direct costs and allocated costs to develop a proposed Care Management rate for approval as part of the annual certification process. This might be demonstrated by use of a cost center for Care Management so administrative overhead allocations can be included in the expense reported in the income statement as developed in the approved rate and submitted to the state service encounter reporting system.

- Trace the calculated and approved rates to the submission of the internal care management services to the encounter reporting submitted by the MCO to the State.

- Trace the total internal care management cost supporting documentation to source documents such as payroll records and review the system rate for reasonableness.

- Trace payments to contracted care management providers to the contracted and DHS approved rate and source claim documents submitted for payment.

- Verify that care management services are accounted for on an incurred basis by reviewing the accounting procedures to assure that any associated payables have been properly captured and accrued for contracted and/or internally provided care management services.

- Review the MCO's process for monthly encounter to financial reconciliation for care management services.

- Verify the incurred amount on the Revenue and Expense statement by calculating:
  - Care management services paid in the current year for any date of service
  - Plus care management services incurred but not paid (IBNR)
  - Less prior year care management services incurred but not paid (IBNR)

9 Financial statement and data certification

Compliance Requirements: The Family Care, Family Care Partnership and PACE Contracts include Federal requirement 42 CFR 438.600, which requires the Managed Care Organization to assure that data submitted to the State is accurate, complete and truthful to the best of their knowledge by signing and submitting:

1) Data Certification Form with each accepted batch of Encounter data
2) Certification Form with each submitted Financial Statement.

Suggested audit procedures:

- Interview the staff person responsible for signing the attestation to assure that adequate controls and verification of the data exist to support of their attestation.
  Possible interview questions include:
  1. How do they know that the data is accurate, complete and truthful?
  2. Who reviews the data and how often is it done?
  3. What checks and balances are in place to assure data accuracy, completeness and truthfulness?

  Example: Reconciliation from the claims and revenue ledgers, the MCO information system used to transfer the data to the state encounter reporting system, to the general ledger accounts. The reconciliation should include:
  - Cost Share Revenue
  - Member Services (including provider payments and refunds)
  - Care Management services

Claims Processing

The MCO is responsible for ensuring that claims submitted are for services actually provided to members, authorized and paid at the contracted. The internal audit function is critical to ensuring that there are no fraudulent claims being paid through the claims processing operations.

Suggested audit procedures:

- Evaluate the MCO's policies and procedures and internal audit function to protect against fraudulent service provider claims.

- Evaluate the internal audit function to ensure that submitted claims are for services actually provided to enrolled members.

- Document staff access to service authorization system and provider contracted rate table evaluate MCO audit of authorization for approved changes.

- Select a sample of claims and evaluate claims processing against the provider contracted rate, authorization, and other validation criteria to ensure accuracy and timeliness of claims processing against the MCO policy and procedure and DHS contract requirements.

- Evaluate follow-up with providers, claims appeals, refunds, and other documentation related to claim sample.

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